Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4202SNF	A. BUILDING _____ B. WING _____	12/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

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Z 000	Initial Comments This Statement of Deficiencies was generated as a result of a State licensure complaint survey conducted at your facility on 10/7/08 and finalized on 12/8/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Skilled Nursing Facilities Regulations, adopted by the Nevada State Board of Health on August 4, 2004. Complaint #NV00019360 was substantiated. See Z 266. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	Z 000		
Z266 SS=G	NAC 449.74477 Pressure Sores Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shell ensure that a patient: 2. With pressure sore receives the services and treatment needed to promote healing, prevent infection and prevent new sores from developing. This Regulation is not met as evidenced by: Based on record and facility policy review and staff interview, the facility failed to provide the necessary treatment and services to prevent the deterioration of a decubitus ulcer for one resident. (#1)	Z266		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z266	Continued From page 1 Findings include: Resident #1 was admitted from his home to the facility on 8/15/08, with diagnoses including decubitus ulcer and diabetes. Record review revealed that Resident #1 was admitted to the facility for wound care with a Vacuum Assisted Dressing (VAC). Physician admission orders, dated 8/15/08, revealed "WOUND CARE WITH WOUND VAC PER DR. ____ PT TO DO WOUND CARE Special instructions: PHYSICAL THERAPY TO DO WOUND CARE PER DR ____'s ORDER". Dr.____ was Physician #1. Record review revealed no evidence that Physician #1 wrote wound care orders regarding Resident #1's buttock ulcer or the wound VAC. No physician orders were found regarding the care of the resident's 3 cm. x 3 cm. left heel ulcer. On 10/7/08, the Director of Nurses (DON) was interviewed. She reported that Physician #1, a surgeon, was not a staff physician at the facility. She stated that Physician #2 was Resident #1's attending physician. Review of the history and physical completed by Physician #2 revealed a primary diagnoses of decubitus ulcer but did not identify the buttock or heel ulcer's grade, size, location or explanation of treatment. In a later interview with the DON on 11/14/08, she confirmed that no physician orders were ever written for the care of the resident's left heel ulcer. Review of the Resident Progress Notes revealed Resident #1's left heel ulcer was observed by nursing staff on 8/20/08, 8/21/08 and 8/22/08.	Z266		

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Z266	Continued From page 2 The dressing was changed on 8/22/08 and minimal drainage was noted. No specific wound treatment was described in the notes. The Treatment Flowsheet dated 8/16/08-9/15/08 revealed no evidence wound care was provided to the resident's left heel ulcer. The DON provided a facility policy and procedure entitled "Dressing Change (Clean) last revised 12/04. Step one of the procedure revealed that the nurse was to review the physician's order for the treatment procedure. Review of the Resident #1's care plan revealed no mention of the left heel wound. The care plan identified the resident's need for a wound VAC to his buttock ulcer as a problem and the sole intervention was "Give Septra DS as order per MD/monitor effectiveness/adverse effects every shift." No specific interventions regarding the resident's VAC dressing were identified. During the 10/7/08 interview, the DON reported that Physician #1 told the nursing staff they were not to touch the resident's buttock ulcer or VAC dressing. She stated, in reference to the wound, that "Nursing didn't manage it because it was ordered that way. The VAC dressing was to be managed by the Physical Therapist only." She stated that she was unaware that there was no order for wound care of the buttocks from Physician #1. She reported that nursing staff monitored the VAC dressing to see if it was still functioning and would call the Physical Therapist (PT #1) whenever there was a problem such as a leak. She reported that the resident moved around a lot and that it was difficult to maintain a seal on the dressing. She reported that she did not know of any problem in regard to PT #1's response time to problems maintaining the VAC dressing.	Z266		

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Z266	Continued From page 3 On 10/7/08, PT #1 was interviewed. He stated that he provided home wound care to Resident #1 prior to his admission to the facility. He stated that Physician #1 told him how he was to manage Resident #1's wound VAC but did not give him a written order for wound care. He stated there were manufacturers protocols for the use of VAC dressings and that he followed them. He stated that he believed Physician #1 wrote or verbally provided the facility with an order for wound care. He stated he was not aware there was no order in the resident's record and did not check for the order. He stated that he was not permitted to accept verbal orders from a physician. PT #1 reported that he was not familiar with the facility's policy and procedures regarding wound care and documentation requirements. Review of facility Policy No:708 (NV) last revised 2/05, revealed "specific treatment orders must be received from the physician identifying the frequency/duration and the diagnosis and ICD-9 code for which the resident will be treated." Review of the Physical Therapist's job description, adopted 8/00 and last revised on 11/06, revealed that one of the prime responsibilities of the therapist was to evaluate and treat resident's per physician order. The job description also revealed that the therapist was to follow all facility policies and procedures with respect to State/Federal Guidelines. The policy and procedure entitled "Dressing Change (Clean)" revealed that the physician's order was to be reviewed prior to the treatment procedure and the wounds color and progress of healing was to be documented. PT #1 stated that it was difficult to maintain a seal	Z266		

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Z266	Continued From page 4 on Resident #1's wound due to the location of his wound. He stated that he was called by nursing staff almost daily due to a break in the VAC dressings seal. Record review revealed that Resident #1 was first seen at the facility by the PT on 8/18/08. A form entitled "Physical Therapy Weekly Treatment Record" revealed the wound measured 4.3 cm. in width, 7.5 cm. in length, and 2.6 cm. in depth. Moderate exudate was noted and the wound VAC was applied. No description of the wound's exudate or appearance of tissues was provided. On 8/19/08, PT #1 documented on the Physical Therapy Weekly Treatment Record that there were "wound VAC problems." A leak at the anal area was noted. A new sponge and suction system was applied. The note did not identify the time of day the leak occurred. The wound was not measured and no description of the wound's exudate or appearance of the wound and surrounding tissues was noted. On 8/20/08, wound measurements were noted to be 6.6 cm. in length, 3.3 cm. in width, and 2 cm. in depth. No description of the wound's exudate or appearance of the tissues was provided. VAC problems were noted to have occurred in the "PM" and a sponge and bandage were reapplied. On 8/21/08, the VAC dressing again leaked and was reapplied. There were no notes written by PT #1 regarding the VAC dressing on 8/22/08, however, a nurses note revealed that the VAC dressing was again changed in the PM by PT #1. The note was written on 8/22/08 at 11:04 PM. In interview on 10/7/08, PT #1 reported that on 8/22/08, the buttock decubitus ulcer appeared to be healing. He stated that the wound decreased in size and did not have signs of infection. He	Z266		

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Z266	Continued From page 5	Z266		

stated the tissues in the wound looked healthy. He stated that he had no need to contact the physician during Resident #1's stay because there were no problems with the wound. He reported that he did not know why the wound deteriorated so quickly, but stated that wounds sometimes do so.

On 8/23/08, Resident #1 developed an elevated temperature and Physician #2 was contacted. The physician ordered Septra, a urinalysis, urine culture and sensitivity and a wound culture with the next VAC change. On 8/24/08, the family requested that Resident #1 be sent to the hospital for evaluation. He was transported by ambulance to the hospital for an elevated temperature and evaluation of his wound.

Resident #1 was admitted to the hospital on 8/24/08. His History and Physical dated 8/24/08, indicated he had a Stage IV decubitus gluteal ulcer that required debridement. A wound consult was ordered and, on 8/25/08, the resident was seen by Physician #1. The consult revealed that the resident "was discharged apparently to (Name of the Nursing Facility) where little management of the wound was done. I do not know if the VAC was kept in place or not, but he presents back today with increasing foul discharge from the area and further breakdown." The wound description read "The skin edges are all dead. There is extensive gangrene all the way around it. There are new areas of breakdown extending down toward the anus with surrounding cellulitis. This is a real mess."

Resident #1's gluteal (buttock) wound was debrided on 8/26/08. The operative report dated 8/26/08, revealed that "It required extensive debridement this time, right down to the sacrum

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Z266	Continued From page 6 and to the coccyx, almost invariably the coccyx going to be involved with infection as the dead tissue extended right down to it. This was not present two weeks ago at the debridement." The resident's left heel ulcer was treated using wet to dry dressings while in the hospital. Severity 3 Scope 1	Z266		